Jane Benson Chan R.Ac, RCRT, R. BIE
Registered, Professional Holistic Practioner and Instructor
603 Argus Road Suite 106 Oakville ON L6J 6G6
Phone: 905-337-5913 Cell: 416-880-1310

Please take a few moments to fill out this questionnaire carefully. All answers will be held strictly confidential. If you have any questions, please ask us. *Please fill in first 5 pages only.* Thank you.

First Name:_____ Last Name:_____ Sex: M / F Age: _____
Address:_____ City: _____ Postal Code: _____
Home Phone: (_____) _____ Work Phone: (_____)_____
Email: _____ Date of Birth: _____ Occupation:_____
Family Physician: _____ Phone No.: (_____)_____
Address:_____ City: _____ Postal Code:
How did you find us? Referred by: _____ ☐ Media ☐ Ad ☐ Street signs ☐ Other

Personal and Family Medical History

Check those that apply:	**Yourself**	Mother	Father	Grandparents	Brother	Sister	Children
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer (note type)							
COPD / Emphysema							
Depression							
Diabetes							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
Hepatitis							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Mental Illness							
Headaches							
Pneumonia							
Stroke							
Thyroid disorder							
Tuberculosis							
Ulcers							
Other							

List any surgeries that you've had (Include the year of the surgery): _____

_____

_____

_____

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Please list all medications and supplements you are taking, including length of use:

Medications (please give name, dose and amount of time on med)

Med _____ Dose_____ Length of use? _____
Med_____ Dose_____ Length of use? _____
Med_____ Dose_____ Length of use? _____
Med_____ Dose_____ Length of use? _____

Supplements/Vitamins/Herbs

Name/brand_____ Dose_____ Length of use? _____
Name/brand_____ Dose_____ Length of use? _____
Name/brand_____ Dose_____ Length of use? _____
Name/brand_____ Dose_____ Length of use? _____

Inquiry

Chief Complaint: _____

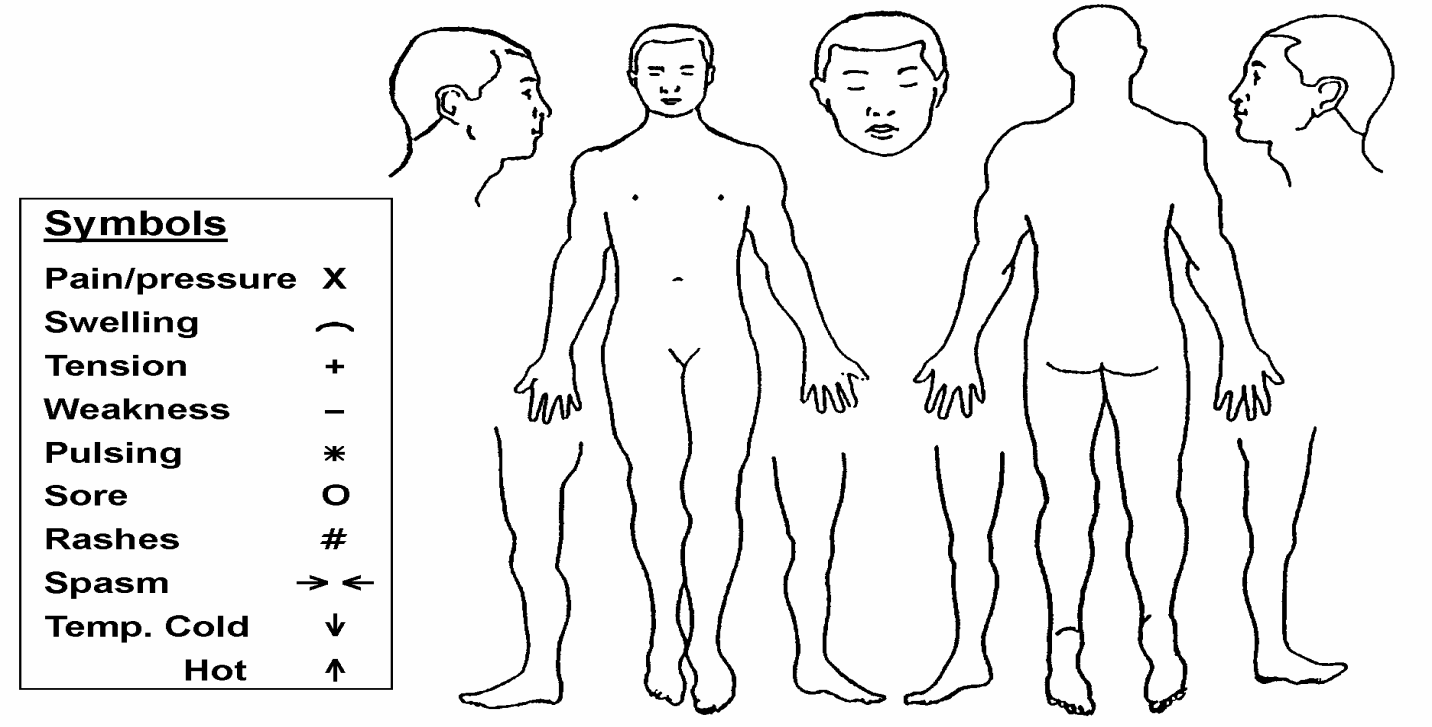
_____

History of the Present Disease

Onset of present condition: _____

Diagnosis by family physician: _____

Location of pain and discomfort:



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Pain:

1 2 3 4 5 6 7 8 9 10 (1 = Minimal pain, 10 = Extreme pain)

- ❑ Dull
- ❑ Lingering
- ❑ Sharp
- ❑ Burning
- ❑ Stabbing
- ❑ Distending
- ❑ Contracting
- ❑ Aggravated / Alleviated by:

Pressure Temp Climate

Head and Body:

- ❑ Headaches
- ❑ Migraines
- ❑ Body aches
- ❑ Joint pain
- ❑ Neck pain
- ❑ Back pain
- ❑ Low back pain
- ❑ Muscle pains
- ❑ Weak limbs
- ❑ Numbness
- ❑ Heaviness
- ❑ Stiffness

_____
_____
_____

Cold and Heat:

- ❑ Tidal Fever
- ❑ Cold
- ❑ Cold hands/feet
- ❑ Cold back
- ❑ Chills
- ❑ Heat
- ❑ Clammy hands/feet
- ❑ Fever

_____
_____

Sweating:

- ❑ Spontaneous
- ❑ With exertion
- ❑ No sweating
- ❑ Hot flashes
- ❑ Local sweats
- ❑ Night sweats

_____
_____

Energy: 1 2 3 4 5 6 7 8 9 10 (1 = Minimal energy, 10 = Maximal energy)

- ❑ Fatigue
- ❑ Fatigues easily
- ❑ Sudden energy drop
- ❑ Dizziness
- ❑ Excess
- ❑ Drowsy
- ❑ Dyspnea / SOB
- ❑ Fainting
- ❑ Heavy feeling

_____
_____

Sleep: _____ Hrs/night

- ❑ Sound, restful
- ❑ Insomnia
- ❑ Heavy sleep
- ❑ Dream disturbed
- ❑ Not restful
- ❑ Grinds teeth

_____
_____

Urine:

- ❑ Normal
- ❑ Polyuria
- ❑ Urgency
- ❑ Incontinence
- ❑ Nocturia
- ❑ Infrequent
- ❑ Dysuria
- ❑ Hematuria
- ❑ Clear
- ❑ Dark
- ❑ Excess
- ❑ Scanty

_____
_____
_____

Stool:

- ❑ Regular
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loose/watery
- ❑ Foul smell
- ❑ Gas
- ❑ Dry, hard
- ❑ Burning
- ❑ Explosive

_____
_____

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Thirst:

- ❑ Thirsty with desire to drink
- ❑ Likes cold drinks
- ❑ Likes hot drinks
- ❑ Thirsty with no desire to drink
- ❑ Dry mouth
- ❑ Bitter taste in mouth
- ❑ Metal taste in mouth

_____

_____

Appetite: 0 1 2 3 4 5 (0 = No appetite, 5 = Heavy appetite)

- ❑ Cravings
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Gas
- ❑ Bloating
- ❑ Heartburn
- ❑ Bad Breath
- ❑ Food Preferences

_____

_____

Emotions:

- ❑ Calm/relaxed
- ❑ Depressive
- ❑ Anxious
- ❑ Angry
- ❑ Irritable
- ❑ Stressed
- ❑ Grief
- ❑ Overthinking
- ❑ Fearful

_____

_____

Lifestyle and Body Type:

- ❑ Smoking
- ❑ Weight gain / loss
- ❑ Thin / Heavy
- ❑ Irregular hours
- ❑ Shift work
- ❑ Regular Exercise
- ❑ Alcohol
- ❑ Caffeine
- ❑ Occupational stress factors: _____

Eyes:

- ❑ Blurry vision
- ❑ Spots in front of eyes
- ❑ Poor vision
- ❑ Eye pain
- ❑ Eyestrain
- ❑ Dry eyes
- ❑ Burning
- ❑ Red
- ❑ Yellow

_____

_____

Ears:

- ❑ Poor Hearing
- ❑ Tinnitus
- ❑ Earaches

_____

Skin and Hair:

- ❑ Rashes
- ❑ Itching
- ❑ Dry skin
- ❑ Ulcerations
- ❑ Eczema
- ❑ Hives
- ❑ Dandruff
- ❑ Hair loss
- ❑ Changes in skin/hair

_____

_____

Gynecology:

- ❑ Regular
- ❑ Irregular
- ❑ Amenorrhea
- ❑ Clots
- ❑ Heavy / Light flow
- ❑ Pale / Dark colour
- ❑ Discharge: _____
- ❑ PMS
- ❑ Pain _____

Age at first period: _____ Age at menopause: _____ Number of Pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last period: _____

Oral contraceptive use: _____ Type:_____ For how long: _____

Other Health Concerns:

_____

_____

_____

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Informed Consent for Traditional Chinese Medicine Treatment

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please ask your attending traditional Chinese medicine practitioner to further explain it all pertinent information's in regards to your traditional Chinese medicine treatment. You may also seek a second opinion from another health care professional, or terminate therapy at any time.

I hereby request and consent to the performance of traditional Chinese medicine treatments and other procedures within the scope of the practice of traditional Chinese medicine on me by the **Jane Chan**, **R.Ac., RCRT, R. BIE** a traditional Chinese medicine practitioner and Acupuncturist named below.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping therapy, Chinese herbal medicine, and electrical stimulation of the acupuncture needles, moxibustion, infrared heat use, Chinese medical nutrition and traditional Chinese medicine counseling, Chinese medical qigong and Chinese manual medicine (soft tissue manipulation and/or joint manipulation).

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is an also common side effect of cupping therapy. The **Jane Chan, R.Ac., RCRT, R. BIE** uses sterile disposable needles and maintains a clean and safe environment at Nourished Health clinic.

I understand that a minority of patients may notice stiffness or soreness after the first few days of treatment by Chinese manual medicine. I understand and am informed that, as in the practice of traditional Chinese medicine, acupuncture and in the practice of Chinese manual medicine there are some risks to treatment, including but not limited to strains, bruising and local pain.

The traditional Chinese medicine herbs (which are from plant, and mineral sources) that have been recommended are traditionally considered safe in the practice of traditional Chinese medicine (TCM) and Acupuncture, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the traditional Chinese medicine practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbs.
I understand that some herbs may be inappropriate during pregnancy. Therefore, I will notify the traditional Chinese medicine practitioner who are caring for me if I am or become pregnant.

I do not expect the traditional Chinese medicine practitioner to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the traditional Chinese medicine practitioner to exercise judgment during the course of treatment which the traditional Chinese medicine practitioner thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of the traditional Chinese medicine therapies and procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Jane Chan, R.Ac., RCRT, R. BIE

Patient's Name _____

Patient's Signature_____ **Date Signed** _____

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FOR TRADITIONAL CHINESE MEDICINE PRACTITIONER USE ONLY.

Inspection, Auscultation, and Olfaction

GENERAL INSPECTION: _____

_____

Shen:

❑ Bright	❑ Deficient	❑ Nervous	Overall Impression: _____
❑ Dull	❑ Excess	❑ Tics/Tremors	_____

Complexion:

❑ Sallow	❑ Flushed	❑ Dry skin	_____
❑ Dim	❑ Malar Flush	❑ Dark Circles	
❑ Pale	❑ Red		_____

LOCAL INSPECTION: _____

_____

AUSCULTATION: _____

❑ Weak voice	❑ Talks rapidly	❑ Rapid breathing	❑ Wheezing
❑ Loud voice	❑ Talks slowly	❑ Sighs a lot	❑ Rattling in throat

OLFACTION: _____

_____

_____

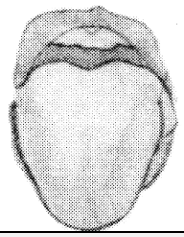
Tongue

Body: _____

Color: _____

Coat: _____

Other Qualities: _____



Palpation

PULSE			LEFT :	RIGHT :
	☐ Full	☐ Empty		
	☐ Rapid	☐ Slow	**HT**	**LU**
	☐ Long	☐ Short	**LV**	**SP**
	☐ Deep	☐ Superficial	**KI-Yin**	**KI-Yang**

Pulse Overall Impression: _____

_____

_____

TCM Disease Diagnosis: _____

TCM Diagnosis

Primary Syndrome Diagnosis: _____

Secondary Syndrome: Diagnosis: _____